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TO: MEMBERS, ASSEMBLY BUDGET SUBCOMMITTEE #1

FROM: DONNE BROWNSEY representing COMP

RE: May Revise Response: DMC realignment and DADP elimination

DATE: May 20, 2011

At this point in time, COMP does not support nor oppose the realignment of the Drug MediCal (DMC) program to the counties with the state required functions being transferred to the Department of Health Care Services (DHCS). Until the details of the split of authority between the state and county administration is available COMP will retain neutrality. We have been assured by the Brown Administration that the key issues requiring state oversight and authority will be retained at the state level. This includes the list of issues enumerated below. Further, we are concerned about the elimination of the Department of Alcohol and Drug. While addiction remains a major societal problem, central to any state system of health care, COMP has made a choice to keep the long view in mind for the DMC program and other addiction services. Retaining these programs until the National Health care system is operational in the state is a top priority. Needless to say, we are distressed by the recommendation to eliminate ADP in the short term.

For the California Opioid Maintenance Providers, (COMP), it is critical to consider the patient-care and cost-shifting implications of any proposal to restructure medication-assisted treatment (MAT) services.

Background

MAT services in California are provided through narcotic treatment programs (NTPs) staffed by multi-disciplinary teams including physicians, nurses and counselors.

NTPs are licensed by the state and governed by stringent state and federal regulations. In addition to state oversight, NTPs are accountable to the federal Center for Substance Abuse Treatment (CSAT) as well as the Drug Enforcement Administration (DEA).

NTPs provide services to approximately 35,000 people in 30 California counties each day. The standard scope of services includes basic medical care, medication administration and supervision as well as regular, ongoing counseling. Some programs provide additional services to their patients including case management, nutrition counseling, parenting classes, child care, benefits advocacy, and more.

Realignment Proposal Considerations for Medication-Assisted Treatment - Letter

NTPs are funded with Drug Medi-Cal and private patient fees. Very few counties (3-4 of which we are aware) provide any county general fund dollars) NTPs receive no SAPT block grant dollars in California.

Up until 1993, counties managed DMC funds at their discretion. As a result, every county decided individually if they would allocate DMC dollars to NTP services. Those that did allocate funding for MAT, arbitrarily limited the number of patients who could receive those services.

In 1993, a lawsuit was brought by a class of patients (*Sobky v. Smoley*) to challenge the limited access of NTP services. The class was successful and the court ruled that counties could not limit access to the program, in effect saying it must be available statewide.

Key considerations for a realignment proposal:

- Most importantly, counties must **not** be empowered to determine if or how many Medi-Cal beneficiaries can access MAT services. It is COMP's understanding that growth potential for caseload will be part of the realignment. Additionally COMP requests that the counties be restricted in any additional regulations that may interfere with providers' ability to service their clients and contracts.
- **Direct state contracts must be retained.** Currently there are 30 counties with NTPs. Of those 30, 8 counties do not contract with providers and LA has both county contracts and providers with direct state contracts. Additionally, there are 3 counties that have only recently executed contracts, begrudgingly, because of a recent state policy to not provide contracts. **This means that at least 10 of 30 (33%) counties may not allow this service under a realignment plan that empowers counties to determine the scope of services.** Please see the attached list of counties.
- It is important to understand with respect to the prior point, that while medical literature is conclusive and consistent that MAT for opiate addicted persons is the most effective and cost effective treatment, social and political mythology are barriers for numerous county Boards of Supervisors to approve clinics in their counties.
- Rates are currently set at the state level, based upon objective cost-data gathered by the state. Cost-control mechanisms already exist in the formula developed by ADP pursuant to AB 2071 (1997). Examples of some cost-controls include a cap on the number of services that can be provided, use of cost-report data that is two-years old and the TBL adopted last year to limit rate increases to actual costs or a deflationary index, whichever is lower. Federal law requires that the state maintain control of setting rates and licensing and certification;
- A crucial issue is to retain our system of NTP clinics in order to transition to the Federal Health Plan in 2014.
- Any realignment plan ought to include the elimination of state regulations (Title 9, CCR). Given the oversight by federal agencies, state oversight is duplicative and inefficient. Furthermore, several current state regulations result in increased cost to programs that could be passed-on to the state. Examples are reduced drug screens and closing clinics on Sunday.